

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/16/2016
NAME OF PROVIDER OR SUPPLIER LEBANON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 NORTH ALTON LEBANON, IL 62254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint #1643145/IL86082	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b 300.1210c 300.1210d)6 300.1220b)2 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/06/16

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S9999	<p>Continued From page 1</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by: Based on interview and record review the facility failed to properly address the psychosocial needs and follow the plan of care for a resident with Dementia, with known fears of water and increased behaviors while showering for 1 of 5 residents (R3) reviewed for individualized care in the sample of 5. This failure resulted in R3's increased behaviors during a shower that resulted in R3's left ankle fracture which required hospitalization and surgical intervention and failed to properly transfer, provide a thorough investigation, and implement progressive interventions for falls for 2 of 5 residents (R2, R3) reviewed for falls in the sample of 5. This failure resulted in R2 having multiple Emergency Room visits requiring intervention for lacerations to the head, concussion and compression fracture. The failure resulted in R3's left ankle fracture requiring hospitalization and surgical intervention.</p> <p>Findings include:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>1. R3's June 2016 Physician Order Sheet documents R3 was admitted to the facility on 6/5/14 with a diagnoses, in part, of: Dementia, aggressive behavior, mental status change, severe Dementia with psychosis, and Alzheimer's. R3's Minimum Data Set (MDS), dated 1/25/16, documents R3 was unable to complete the cognition interview, resident is rarely/never understood. R4's MDS, dated 1/25/16, documents R4 requires extensive assistance with two staff members for toileting and showering. The MDS further documents R3 does not exhibit behavioral symptoms. The MDS also documents R3 rejected care that is necessary to achieve the resident's goals for healing and well-being.</p> <p>R3's Care Plan, dated 6/5/14, documents: Behavior, with a review date of 1/25/16: "Resident is known/has history of displaying inappropriate behavior and or resisting care/services. Specific behavior exhibited, resists care, physically and verbally aggressive to staff, delusional about food preferences. Related diagnosis/condition, dementia, depression, psychosis unspecified." Cognitive Loss/Dementia, with a start date of 6/20/14: Behavior exhibited.."refusal/fear of water showers." Resident's specific information can be physically/verbally abusive when resisting care. Falls with review date of 1/25/16: "Resident has risk factors that require monitoring and intervention to reduce potential for self injury. A) See also Behavior care plan. minimize fall risk through reducing agitation and impulsive behavior." Behavior: "Use two staff members for showers for safety due to resisting care. Fears water or lotion on skin or hair." Multiple Interventions for Previous Falls noted under the Fall Care Plan. Activity of Daily Living (ADL)</p>	S9999			

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S9999	<p>Continued From page 3</p> <p>Function Rehab, with start date of 6/20/14 and review date of 1/25/16: "Self care deficit-needs supervision and or assist to complete quality care and or poorly motivated to complete ADL. As evidenced by does not like clothes to touch floor when dressing and is fearful of anything wet touching hair or skin which results in resisting showers or sponge baths. Resident specific information/preferences will need two staff to bath resident. A) will receive shower. Will need two staff to bath resident due to fear of water."</p> <p>R3's Bowel Assessment dated 11/2/15 documents: "Staff assist (R3) to bathroom, requires 2 assist frequently with toileting needs related to agitation during care."</p> <p>R3's Behavior Monitoring Record For March, April, May and June 2016 documents: Agitation at staff. Documentation for 3/17/16 Record states "leaning, twisting with assisted transfer stating 'I'm going to fall'." Documentation for 4/13/16 Record states "being ambulated in hallway, calling out 'Don't hurt me. Don't drop me'." June's Tracking is blank.</p> <p>R3's SBAR (Situation, Background, Assessment, Recommendation) Communication Form, dated 4/14/16, documents: Resident Evaluation: Mental Status Evaluation: dementia, no changes observed, Functional Status Evaluation: decreased mobility, Behavioral Evaluation: depression, social withdrawal, Respiratory Evaluation: (blank), Cardiovascular Evaluation: (blank), Abdominal/GI Evaluation: date of last bowel movement: 4/14/16, Situation: (entire section-blank), Background: (entire section-blank).</p> <p>R3's Social Service Progress Notes documents: "7/10/15, IDT(Interdisciplinary Team) met this</p>	S9999			

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S9999	<p>Continued From page 4</p> <p>morning to discuss (R3's) behaviors. (R3) hit CNA (Certified Nurse Assistant) who was assisting her out of bed. Team will continue to monitor. 9/11/15 IDT met this morning to discuss behavior tracking. (R3) scratched CNA while attempting to assist her to dinner. Team will continue to redirect and monitor. 9/18/15 IDT met this morning to discuss behavior tracking. (R3) was resistive with CNAs trying to give her a shower and was difficult to calm down. Team will continue to redirect and monitor. 11/13/15 IDT met this morning to discuss behavior tracking. (R3) became agitated with staff during ADL care as well as resistive. team redirected and will continue to monitor. 11/20/15 IDT met this morning to discuss behavior tracking. (R3) became agitated during shower and ADL care and resisting care. Staff redirecting and will continue to monitor. 12/4/15 IDT met this morning to discuss behavior tracking. (R3) was becoming agitated during shower care. Staff redirected and will continue to monitor." The next entry is 4/14/16 documenting the hospital requesting R3's guardianship paperwork.</p> <p>R3's Nursing Notes dated 4/14/16 documents in part: "7:20 AM, Called to shower room by (E5, CNA). She (R3) lunged, started slipping. (E5) had tried to straighten (R3) prior to impact of extended left leg against commode base. (R3) now lowered to floor into sitting position. Left lower leg/ankle area with a 1 cm (centimeter) whitened area with hard object. Feet beneath this area. Deviation of foot of inner rotation-welling occurring...Stabilized Left lower leg using magazines and ace wrap. no wt (weight) bearing as 4 transfer (R3) to w/c (wheelchair) then to (R3) bed." 0730, "call placed to (Z1, Nurse Practitioner) returning call with orders to send to ER (Emergency Room) for evaluation r/t (related</p>	S9999			

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S9999	<p>Continued From page 5</p> <p>to) left lower leg dislocation, edema, and pain." "835 AM Call received from hospital inquiring to how LL (left lower) leg trauma occurred. Told of large loose stool incontinence required shower for cleansing, (R3) lunged and slipped." (Z2, Medical Doctor) "indicates fracture has occurred, surgical intervention being considered." Nursing Notes dated 4/15/16, 9:00 AM, documents "IDT meeting held with review of previous fall. Interventions to educate staff assistance of 2 for showering."</p> <p>R3's Hospitalist History and Physical dated 4/14/16 documents "Admission: HPI (History of Present Illness); 76 year-old with history of Alzheimer's dementia present to the ED (Emergency Department) from NH (Nursing Home) for left ankle pain and deformity s/p (status post) witnessed fall this morning in the shower. Per NH nurse, (R3) was wearing a gait belt and her leg slipped in the shower and she slid into a commode. The aide reported hearing a pop. Upon exam, unable to obtain any history from (R3) due to confusion. Per nurse, her baseline is A/O (alert and orientated) x 0. History obtained from ED records. Upon arrival to ED, the physical noted purple discoloration of left foot and second and 3rd toes on right foot, which he noted to greatly improve close to normal color. Physical Exam: Musculoskeletal. Extremities; ROM (Range of Motion) grossly intact, Pain with ROM (left ankle), ROM decreased (left ankle), other (left ankle wit horoglass posterior splint in place, foot warm DP (dorsalis pedis) pulse 2+, neurovascular intact, slight purple discoloration to 2nd and 3rd toes of right root. Other Test Results: Left ankle x-ray: decreased mineralization, trimalleolar fracture with mild displacement of fracture ligaments. Assessment/Plan: Problem List (1) Trimalleolar Fracture of ankle, closed. Assessment/Plan:</p>	S9999			

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S9999	<p>Continued From page 6</p> <p>X-ray left ankle reveals trimalleolar fracture with mild displacement of fracture ligaments. Admit to medical floor. Orthopedic surgeon consulted. Plans for surgery. (3) Alzheimer's dementia: Assessment/Plan Continue home regimen fall precautions."</p> <p>R3's Orthopedic Consult dated 4/14/16 documents in part: "Assessment/Plan: Problem List (1) Closed trimalleolar fracture of left ankle. Overall the ankle really shows significant displacement and a trimalleolar fracture has an inherent instability. Therefor the recommendation is for an open reduction internal fixation to reposition the alignment and allow for rigid fixation. This would also allow for a little earlier mobilization and weight bearing. However still carry the inherent risk of surgery. Conversely I think to treat this from a close/conservative standpoint is going to leave her with a completely dysfunctional ankle for which she would have difficulty even with limited weightbearing...We'll plan on proceeding to the operating room on 4/15/16 at 1 PM as long as patient is stable for surgery."</p> <p>R3's Operative Report, dated 4/15/16, documents in part: "Procedure Performed: open reduction internal fixation left trimalleolar ankle fracture. Open reduction internal fixation to include a lateral plate and screw technique for the lateral malleolus fracture. 2 screw fixation for the medial malleolus fracture. No fixation required for the posterior malleolus fracture which reduced after the bimalleolar fixation."</p> <p>On 6/14/16 at 10:08 AM, E6, CNA, stated she has taken care of R3, but was not working the day R3 fell. E6 stated R3 was in the dementia care unit before her fall and she was walking and</p>	S9999			

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S9999	<p>Continued From page 7</p> <p>required one staff member for assistance for showers. E6 stated she does not know of R3's fall history because she just started at the facility in May.</p> <p>On 6/14/16 at 10:11 AM, E7, CNA, stated she took care of R3 after surgery and is unsure if she had any previous falls. E7 stated she thinks R3 walked around before fall, but doesn't know how fall happened. E7 stated she started at the facility in April.</p> <p>On 6/14/16 at 10:30 AM, E1, Administrator, stated E19, Registered Nurse (RN), who was working the day R3 fell is no longer an employee of the facility. E1 stated fall investigations are part of the Quality Assurance and the facility does not give them out. E1 stated Care Plans are in the binder and is the most updated and working Care Plan for residents. E1 stated SBAR is in residents' charts and document fall information. E1 stated the facility has been inservicing on filling out the SBAR completely.</p> <p>On 6/14/16 at 12:38 PM, E4, Licensed Practical Nurse, LPN, stated she works the 200 hall and dementia unit. E4 stated she worked prior to R3's fall in April. E4 stated she was unsure if she was working as a CNA or LPN during this time since she just received LPN license in March/April. E4 stated R3 was dependent on staff for at least most ADLs. E4 stated R3 required at least 2 staff members for showers, and toileting R3 was at least 1 staff member. E4 stated R3 would ambulate, but she wasn't steady and R3 would always say she was going to fall. E4 stated she did not believe R3 had a history of falls. E4 stated she was not working the day R3 fell, but was told R3 pulled away while being toileted. On 6/14/16 at 2:21 PM, E4 stated R3</p>	S9999			

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S9999	<p>Continued From page 8</p> <p>had behaviors. E4 stated R3 would not want to get up, or take medications sometimes. E4 stated R3 was uncooperative with showers or any care. E4 stated R3 would pull away from staff and state she (R3) wants to go back to her room or say "No." E4 stated R3 was never agreeable with any care.</p> <p>On 6/14/16 at 1:00 PM, E5, CNA, stated she was the CNA who assisted R3 in the shower on 4/14/16 when R3 fell. E5 stated R3 had a bowel movement and went to shower R3 to clean her up. E5 stated she was drying R3 off and R3 jumped up and started walking swiftly towards the toilet. E5 stated R3's foot slipped and turned and hit ankle on the toilet and then R3 sat down on the toilet. E5 stated she called for help and E19 came in. E5 stated E19 assessed R3 and called in E3, LPN, Resident Care Coordinator (RCC), and it took 3 staff to get R3 up and put her in wheelchair. E5 stated she didn't know if R3 had any history of falls. E5 stated R3 was unsteady and R3 required one staff member for showering, toileting or ADLs.</p> <p>2. R2's Admission Record, undated, documents R2 was admitted 11/14/11. R2's June 2016 Physicians Order Sheet (POS) documents diagnosis in part, Major Depressive Disorder, Psychosis, RT CVA (Right Cerebrovasuclar Accident), Lt (Left) Hemiplegia, Alzheimer's Dementia, and Bilateral AKA (above knee amputation).</p> <p>R2's MDS dated 5/16/16 and 9/16/15 both document R2 is moderately impaired, is only able to stabilize with staff assistance during surface to surface transfers, has impairment to one side of his upper extremity and has a history of falls.</p>	S9999			

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S9999	Continued From page 9 R2's Care Plan last reviewed 5/16/16 documents in part, "Falls: Potential for falls related to bilateral AKA, has balance issues, CVA with left hemiplegia and is incontinent." Interventions, "9/11/15: (R2) request seat belt on while up in wheelchair related feels weak, able to remove seat belt on own. (R2) does not have any legs. 11/23/15: Physical Therapy/Occupational Therapy (PT/OT) to evaluate and treat related increased weakness. 11/17/16 Educate (R2) to go to bed when tired. 11/29/15: Re-educate (R2) to use reacher when something out of reach. 3/19/16: Sent to Emergency Room and returned with sutures done lip received tetanus at hospital. (R2 stated he felt dizzy and hit mouth on night stand). Monitor suture site for signs and symptoms of infection, remove as ordered. PRN (as needed) pain meds. 5/18/16: Re-educate staff/(R2) to have help with transfers and wait for assistance. 5/29/16: Frequent reminders for proper wheelchair positioning. 6/6/16: Seat belt repositioned on wheelchair to allow for better trunk control. 6/8/16: Self releasing seat belt alarm was added today. OT to evaluate for positioning." R2's Fall Risk Assessments, dated 9/16/15, 12/8/15, 2/29/16, 4/29/16 and 5/16/16, document R2 is a high risk for falls. R2's Physical Therapy Plans of Care, dated 6/13/16 and 12/03/15, both document, "Functional Deficits: Balance, Fall Risk - moderate risk and Balance, Fall Recovery-moderately impaired." R2's Physical Restraint/Enabler Assessment, dated 9/11/15, documents, "Mental Status: Alert: Yes, Short Attention Span: No, Orientated to:	S9999		

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S9999	<p>Continued From page 10</p> <p>Person and Place, Disorientated: Intermittent. Balance When Sitting: Falls forward: Yes, Falls/Leans sideways: Yes to Right, Slumps: Yes. Recovery of Balance (while sitting): Forward: Yes, Backward: No, Sideways: Yes. Ambulation: Does not ambulate related to both above knee amputations. Describe Risk versus Benefits: able to release seat belt of own/command. (R2) request self release belt for positioning, he is a bilateral AKA, with paralysis on right side, uses left arm/hand for mobility of wheelchair. (R2) states seat belt will keep him in his wheelchair, not a restraint. Reviewed 12/8/15 with no changes. 6/8/16 self releasing seat belt alarm was added to alert staff of (R2) leaning over in wheelchair related to no lower extremities, poor trunk control."</p> <p>R2's Nurse's Note, dated 10/27/15 at 6:20 PM, documents in part, "Called to outside patio, found (R2) laying on ground on his back in front of wheelchair. Other (alert) residents stated he started sliding down and eventually slid out of wheelchair underneath wheelchair... No bruises or apparent injuries." No other documentation found in R2's Clinical Record for this fall.</p> <p>R2's Nurse's Note, dated 11/17/15 at 7:00 PM, documents in part, "Called to TV room per CNA. Found (R2) laying on floor on his back. (R2) had removed his seat belt and fell asleep causing him to fall face first into the floor. (R2) has a 3.3 x 1.6 cm (centimeter) laceration to midforehead. Complaint of headache... Orders received to send to ER (Emergency Room)."</p> <p>R2's Nurses Note, dated 11/17/15 at 11:45 PM, documents in part, "(R2) arrived back to facility via stretcher. (R2) has 8 sutures to cent (center) of forehead."</p>	S9999			

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S9999	Continued From page 11 The Facility's Final Report for R2, dated 11/20/15, documents in part, "On 11/17/15 at 7:00 PM (R2) was observed on the floor in the TV room. He was assessed by the nurse and noted to have a laceration to forehead. Physician and family notified with orders to send to ER for evaluation where he received sutures to the laceration. During the investigation (R2) stated that he was watching TV and fell asleep causing him to lean forward resulting in fall. (R2) wears a self releasing seat belt as a reminder which he reports that he had unfastened while watching TV prior to the fall. The fall was a result of (R2) falling asleep in his chair while watching TV. The IDT met, reviewed and residents care plan has been updated to reflect current status." R2's Nurse's Note dated 11/29/15 at 7:45 documents in part, "Heard (R2) yelling, went to see what was going on when nurse walked into room (R2) noted to be sitting in the wheelchair his head was on the floor. (R2) sat up with assistance unable to let us know what happened just motioned to the floor, no item on the floor to be picked up. No red marks or bleeding to forehead. No red mark to abdomen where seat belt was in place attached in place and around waist." No other documentation found in R2's Clinical Record for this fall. R2's Nurse's Note, dated 3/19/16 at 4:40 PM, documents in part, "This nurses heard resident yelling for help. Upon entering room this nurse found (R2) slumped over in his wheelchair with large amount of blood on floor, beside table and bottom part of bed... Noted (R2) to have a 2 inch deep laceration above upper lip.. (R2) stated he was dizzy and went to his room to lay down and collapsed... New order received to send to	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/16/2016
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S9999	<p>Continued From page 12</p> <p>Emergency Room."</p> <p>R2's Nurses's Note, dated 3/20/16 at 2:00 AM, documents in part, "(R2) received 5 stitches to upper lip. (R2) received a tetanus shot."</p> <p>The Facility's Final Report for R2, dated 3/26/16, documents in part, "On 3/19/16 at approximately 4:10 PM (R2) was observed leaning over on his nightstand while still in his wheelchair and assessed by the nurse with a laceration to his upper lip. Physician and family notified with orders to send to the ER where he received sutures. The facility initiated investigation per protocol. Staff reported that (R2) passed the nurse in the hallway stated that he was dizzy and going to his room. The nurse went to (R2's) room where he was noted to be leaning over on his nightstand while still in his wheelchair with laceration to his upper lip. The laceration was a result of (R2) having dizziness and leaning over night stand will still in his wheelchair. The room was assessed with no safety concerns noted. The IDT reviewed and updated care plan reflect current status."</p> <p>R2's Nurse's Note, dated 5/8/16, untimed, documents in part, "Called to room by nurse, (R2) noted on floor on back, states (I fell from chair.)"</p> <p>R2's Nurse's Note, dated 5/8/16 at 10:00 PM, documents, "Sent to hospital Emergency Room for evaluation."</p> <p>R2's Nurse's Note, dated 5/9/16 at 1:30 AM, documents in part, "(R2) returned to facility with DX (diagnosis): of Brain Concussion." On the same day, R2's Nurses' Notes document at 4:00 PM "Neuro checks WNL (within normal limits). See neuro/head trauma assessment form." No</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>other documentation found in R2's Clinical Record for this fall.</p> <p>R2's Emergency Department (ED) Provider Documentation sheet created 5/9/16 documents in part, "ED Arrival Date: 5/8/16. History of Present Illness, Chief Complaint: Head Injury. 74 year old male nursing home resident who fell while transferring from the wheelchair and struck his head. (R2) is on blood thinners. No LOC (loss of consciousness). No other injuries. General Appearance: Mild Distress: Well Developed: Well Nourished. Diagnosis/Impression: Primary Impression: Brain concussion."</p> <p>R2's Nurses Note, dated 5/29/16 at 9:55 PM, documents, "See SBAR related to fall."</p> <p>SBAR Communication Form for R2, dated 5/29/16, documents in part, "Situation: Things that make the condition or symptom worse are (R2) removing seatbelt. Things that make the condition or symptom better are wearing seatbelt. Resident Evaluation: 10. Neurological Evaluation, abnormal speech, dizziness and unsteadiness. Appearance: (R2) was laying on his back on floor. He stated he hit his head. (R2 does have a small goose egg to right forehead) Nursing Notes: (R2) had undone his seatbelt and was leaning forward and toppled out of his chair."</p> <p>R2's Nurses's Note, dated 6/6/16 at 9:50 AM, documents in part, "(R2) was leaving (R2's) Room, when he fell to the floor hitting his head. This caused a small laceration on his forehead. Sent to hospital. Transferred via ambulance."</p> <p>R2's Nurse's Note, dated 6/6/16 at 2:30 PM, documents in part, "(R2) returned to facility via</p>	S9999			

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S9999	<p>Continued From page 14</p> <p>ambulance.. Laceration to right forehead measures 2 cm with 3 sutures dry and intact."</p> <p>R2's ED Provider Documentation sheet created 6/6/16 documents in part, "ED Arrival Date 6/6/16. History of Present Illness, Chief Complaint: Head Injury. 74 year old male from nursing home after a mechanical fall from wheelchair. (R2) at baseline significantly limited in his ability to communicate. Today he is awake, eyes open, complaint of facial pain and neck pain, unable to quantify, unable to provide additional descriptors, unsure why he fell or if he is able to tell me (Z4, ED Physician). No loss of consciousness, reportedly witnessed by staff, 911 called. Has a laceration on his forehead with a dressing in place. History of right sided contractures and bilateral AKA's. Normally his is orientated x 1-2, here will tell me (Z4) his name is (R2). Procedures, Laceration Location Description: Right (side of forehead), Laceration Description: Linear, Length: 3 cm, Number of Sutures: 3. Diagnosis/Impression: Primary Impression: Laceration of head, Additional Impression: Traumatic hematoma of forehead."</p> <p>R2's Radiology Report, dated 6/6/16, documents, "Procedure Description: CT (Cat Scan) Lumbar Spine WO (without contrast), Impression: Mild compression fracture deformity superior endplate of L2 of indeterminate age. Findings: L1-2: Spondylosis, Concern for recent superior endplate mild compression fracture L1."</p> <p>The Facility's Final Report for R2, dated 6/10/16, documents in part, "On 6/6/16 at approximately 9:50 AM, (R2) was propelling himself in his wheelchair out of his room and fell forward out of the wheelchair. (R2) does wear a seat belt to aid in trunk stability due to his bilateral AKA. At the</p>	S9999			

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S9999	<p>Continued From page 15</p> <p>time of the fall (R2's) seat belt was unbuckled. (R2) is able to undo the seat belt and does at time. When asked if he unbuckled his seat belt, he stated he was not sure. In conclusion, the facility has determined that (R2) fell as a result of trunk instability due to not having his seat belt buckled. It was determined that he unbuckled the seat belt and he has been educated on the importance of keeping it buckled. The IDT met, new interventions were discussed and his care plan has been updated to reflect the changes."</p> <p>R2's Nurse's Note, dated 6/8/16 at 12:30 PM, documents in part, "(R2) in tv room reaching for a magazine. Seat belt was intact but (R2) able to unlock. (R2) fell hitting his posterior head causing 2 cm (centimeter) laceration. Pressure dressing was applied. Bleed stopped. C/O (complaint of) left shoulder and back pain... Ambulance notified for transfer to hospital."</p> <p>R2's Nurse's Note, dated 6/8/16 at 6:35 PM, documents in part, "Resident returned to facility via stretcher/ambulance, accompanied per 2 attendants with 3 staples dry and intact to posterior scalp."</p> <p>SBAR dated 6/8/16 documents R2 had a decreased level of consciousness (sleepy lethargic), new pain with complaint of left shoulder pain and back pain.</p> <p>The Facility's Final Report for R2, dated 6/13/16, documents in part, "On 6/8/16 at approximately 12:30 PM, (R2) was noted to be lying on the floor on his back in the TV area. Noted a laceration to the back of his head and he was complaining of back and shoulder pain. New order received to send to the ER for further evaluation and treatment. While at the ER, sutures were placed</p>	S9999			

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S9999	<p>Continued From page 16</p> <p>to close the laceration. (R2) stated he was reaching to get a magazine off of the shelf and fell out of wheelchair. (R2) does wear a seat belt to aid in trunk stability due to his bilateral AKA. Recently his seat belt was moved from his pelvis area to better fit around his chest area to aid in truck stability. At the time of the fall (R2's) seat belt was unbuckled. The CNA that was assigned to (R2) stated earlier in the day (R2) had unbuckled his seat belt and she buckled it and educated him on the importance of keeping it buckled. The facility determined that (R2) fell as a result of trunk instability due to not having his seat belt buckled. The IDT met, new interventions were discussed and his care plan has been updated to reflect the changes."</p> <p>R2's ED Provider Documentation sheet created 6/8/16 documents in part, "ED Arrival Date 6/8/16. History of Present Illness, Chief Complaint: Head Injury. 75 year old male via EMS (Emergency Medical Services) who I (Z4) am familiar with from earlier this week after a a similar fall. Today (R2) was reportedly reaching for something in the dining room and fell out of his chair striking the back of his head, no LOC (loss of consciousness), denies neck pain, reportedly has a scalp laceration on the back of his head, denies chest pain or dyspnea, no abdominal pain, no other complaints, rates pain (god d***). Procedures, the 3 cm linear scalp laceration was prepped and draped in the sterile fashion. The galea was notable intact and the skin was closed with three staples. Diagnosis/Impression: Primary Impression: Scalp laceration, Additional Impression: Scalp hematoma."</p> <p>On 6/13/16 at 1:10 PM, R2 was sitting in the hallway with a 1 inch laceration about his right eye. At that time, R2 was wearing a seat belt up</p>	S9999			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEBANON CARE CENTER

**1201 NORTH ALTON
LEBANON, IL 62254**

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S9999	<p>Continued From page 17</p> <p>under his upper abdomen.</p> <p>On 6/15/16 at 8:25 AM, E3, LPN, asked R2 to remove his seat belt. R2 then took his left hand grabbed the belt from under his chest and released the Velcro belt.</p> <p>On 6/13/16 at 3:00 PM, R2 stated that he has fallen 6 or 7 times lately and he now is wearing a new seat belt that sits higher on his abdomen. He then stated that he likes the new belt and it has an alarm on it. He then stated that he is very scared that he has had all of the falls.</p> <p>On 6/13/16 at 3:45 PM, E3 stated that R2 repeatedly takes off his seat belt and always forgets to ask for help. E3 also stated that R2 will lean over too far and doesn't realize his seat belt is not latched.</p> <p>On 6/14/16 at 2:15 PM, E11, CNA, stated that R2's has a history of falls and thinks he needs something on his chest because he seems to go head first.</p> <p>On 6/15/16 at 9:15 AM, E1 stated that she has mixed feeling on whether or not re-education on R2 was effective or not.</p> <p>On 6/14/16 at 2:22 PM, E12, CNA, stated that R2's has a history of falls and he does not always wear his seat belt and frequently takes it off. E12 then stated that R2 refuses and gets aggressive with us when we try to put it on him. E12 then stated that R2 is top heavy and maybe needs a harness or a different chair to help him keep up because he always leans over and has some balance problems. E12 also stated, "The seat belt is helping, but he can take it off so it is</p>	S9999		

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S9999	<p>Continued From page 18</p> <p>useless."</p> <p>On 6/14/16 at 1:45 PM, E1, Administrator, stated that the fall investigations are QA (Quality Assurance) and the facility does not give them out.</p> <p>On 6/15/16 at 9:35 AM, E15 stated that R2's seat belt is used as a reminder not to lean over too far and to prevent falls. E15 stated that R2 is supposed to have a reacher to pick up items that he sees on the floor, but he does not always carry that with him. She then stated that the reacher was an intervention because of falls. E15 stated she felt the interventions for R2's falls were progressive at the time implemented for each fall.</p> <p>On 6/15/16 at 11:20 AM, E16, Program Director of Therapy Department, stated R2 has a seat belt to help with fall prevention. E16 then stated that R2's previous seat belt was initially effective, but over time became less effective.</p> <p>On 6/15/16 at 10:15 AM, E21, Regional Nurse, stated that she felt the interventions put into place for R2 after his falls are progressive. E21 also stated that no intervention is going to be 100% effective. E21 stated she was unsure if orthostatic blood pressures were done after the 3/19/16 fall when R2 complained he was dizzy and then fell. No documentation that blood pressure done was provided.</p> <p>On 6/15/16 at 12:00 PM during a telephone interview, E2, DON, stated that R2's seat belt is used for trunk stability, bi-lateral seating and positioning. E2 stated she was the interim DON and had been here since 5/14/16 and was only</p>	S9999			

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S9999	<p>Continued From page 19</p> <p>familiar with R2's last two interventions for falls.</p> <p>On 6/15/16 at 4:10 PM, Z4, Medical Doctor, (MD) stated that R2 had a mild compression fracture that was noted on a recent ED visit for falls. Z4 stated he was unsure of R2's prior falls, but that the compression fracture was related to a recent fall. Z4 stated he didn't put the compression fracture on the diagnosis list for the 6/6/16 ED visit for a fall because he felt it was from a previous fall. Z4 further stated he had seen R2 twice in a 2 day period in the ED for falls and felt the facility could be doing more to prevent R2 from falling.</p> <p>Facility's Fall Prevention Interventions List dated 9/3/15 documents 42 interventions used by the facility in preventing falls. The interventions included from the list on R2's Care Plan are #4. Personal alarm, #9. Positioning in chair, #34 Physical therapy referral for ambulation, transfer training, strengthening #35. Occupational therapy referral for positioning. No other interventions were documented for R2.</p> <p>(B)</p> <p>300.690b)c)</p> <p>Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable</p>	S9999			

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S9999	<p>Continued From page 20</p> <p>incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.</p> <p>These requirement are not met as evidenced by: Based on interview and record review the facility failed to notify the Department of a serious injury for 1 of 5 residents (R2) reviewed for falls in the sample of 5.</p> <p>Findings include:</p> <p>1. R2's Nurse's Note, dated 5/8/18, untimed, documents in part, "Called to room by nurse, (R2) noted on floor on back, states (I fell from chair.)"</p> <p>R2's Nurse's Note, dated 5/8/16 at 10:00 PM, documents, "Sent to hospital Emergency Room for evaluation."</p> <p>R2's Nurse's Note, dated 5/9/16 at 1:30 AM, documents in part, "(R2) returned to facility with DX (diagnosis): of Brain Concussion." On the same day, R2's Nurses' Notes document at 4:00 PM "Neuro checks WNL (within normal limits). See neuro/head trauma assessment form." No other documentation found in R2's Clinical Record for this fall.</p>	S9999		

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S9999	<p>Continued From page 21</p> <p>R2's NeuroHead Trauma Assessment, dated 5/8/16, documents R2 was being monitored after his concussion. It also documents R2 was out to the hospital on 5/8/16 started his abnormal neuro assessment.</p> <p>R2's Emergency Department (ED) Provider Documentation sheet from the local hospital created 5/9/16 documents in part, "ED Arrival Date: 5/8/16. History of Present Illness, Chief Complaint: Head Injury. 74 year old male nursing home resident who fell while transferring from the wheelchair and struck his head. (R2) is on blood thinners. No LOC (loss of consciousness). No other injuries. General Appearance: Mild Distress: Well Developed: Well Nourished. Diagnosis/Impression: Primary Impression: Brain concussion."</p> <p>On 6/14/16 at 9:20 AM, E1, Administrator stated that she did not report R2's fall on 5/8/16 to the Department.</p> <p>On 6/15/16 at 10:15 AM, E21, Corporate Nurse, stated they did not need to report the fall for R2 on 5/8/16 because, "it was just a concussion." E21 then stated the documentation in the chart was just a nurse to nurse report.</p> <p>On 6/15/16 at 10:15 AM, E1 also stated that they did not report R2's fall on 5/8/16 to the Department because it was just a concussion and stated it did not require further interventions.</p> <p>Mayoclinic.org defines concussion as, "A concussion is a traumatic brain injury that alters the way your brain functions." It also documents, "every concussion injures your brain to some extent."</p> <p style="text-align: center;">(B)</p>	S9999		

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